THE PSYCHIATRIC APPROACH TO TUBERCULOSIS*

B. CROWHURST ARCHER, M.D., *Durban*

The behaviour of a patient and his attitude towards an illness will depend upon what he thinks about his illness, what he considers to be its cause, and how he believes others regard him as a diseased person.

Coleman[1] has pointed out that what happens to the personality in an illness depends on a number of factors, including age and sex; the parent-child relationship (in children); the nature of the symptoms—the way they develop and the after-effects; the course of the illness and the extent of its threat to life and physical integrity; and, finally, the folklore associated with the particular illness which, for each individual, becomes translated into a kind of personal mythology.

The psychiatrist, as a physician, is concerned not only with the function of the individual organs of the human body, but also with the health of the human being as one integrated and inseparable whole. Moreover, he is interested in the social forces which facilitate or retard emotional adjustment in the individual and in the group.

This multi-disciplined approach to the problem of illness attempts to coordinate thinking in the various biological sciences with the relevant psychological and social data, in order to explore the complexity of the disease-reaction, rather than reduce it to the conceptual framework of any particular discipline. I believe that this approach merits serious consideration in all illness; particularly in a chronic illness like tuberculosis which has proved resistant to approaches based on the tenets of a single discipline.

EMOTIONAL FACTORS

Holmes[2] said that cultural conflict contributed significantly to the natural history of tuberculosis. He contended that the patient's emotional adjustment almost invariably broke down 2 years before the onset or relapse of the disease. It was the increased stress of life upon individuals, who were no longer able to resolve their emotional problems or achieve satisfaction in life, that precipitated the development of tuberculosis.

Day[3] pointed out that tuberculosis differed from the ordinary psychosomatic diseases such as peptic ulcer and hypertension, where, presumably, an emotional habit caused symbolic functional changes which, in turn, if they persisted, caused organic physical changes. Not everyone, he said, can develop tuberculosis 'to order'. Tuberculosis was found in persons of all grades of intelligence in whom it differed again from such psychosomatic disorders, as migraine and asthma; to 'qualify' for these diseases 'it is almost essential to be up to school certificate standard'.

Coleman[4], on the other hand, said that no particular type of personality was particularly prone to tuberculosis, nor was it possible to show unequivocally that emotional factors played an important role in its pathogenesis, although there were instances in which the illness seemed to have arisen in close association with states of tension and stress. It is interesting to record that a higher percentage of obsessive compulsive personalities are found among tuberculous patients than in the population as a whole.

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There are, however, typical emotional responses to the diagnosis and treatment of tuberculosis which are of importance to both the clinician and the hospital administrator. For example, when a patient first learns that he is suffering from tuberculosis, he often refuses to accept the fact of illness or, if he does, only accepts it intellectually and does not prepare himself for a new mode of life or an altered daily routine. The common emotional reactions to this insidious disease is a mild form of anxiety and depression and, as a defence, the patient often develops an attitude of defiance and ultra-cheerfulness, or a kind of repressed hostility which expresses itself in a general 'touchiness' towards the nursing staff and his associates, not unlike the reaction commonly seen in those suffering from essential hypertension. Apathy is rare and occurs in early and advanced stages of the disease and represents, if not a toxic origin, a withdrawal from an otherwise unbearable situation. Finally, since enforced rest is such an essential principle of the treatment of tuberculosis, protracted hospitalization itself tends to create a disabling neurotic condition.

THE HOSPITAL

The diagnosis of tuberculosis is always a shock to the patient. However, if the family doctor handles the situation satisfactorily, the patient will enter hospital with some anxiety, but also with the hope of recovery. It is therefore essential that the physician should understand the personality of the patient—his capacity for personal adjustment and his various emotional stresses—if he is to help him settle down in the hospital environment, maintain his hope of recovery, and prevent his irregular discharge.

The physician should appreciate that if he does little to ameliorate his patient's attitude of rebellion, suspicion and quarrelsomeness, then hospital life will become miserable for the patient as well as for those who have to deal with him; irregular discharges will occur and future rehabilitation will become impossible. If, however, the physician is sensitive to the personal problems of his patient, he will find that the common emotions of fear, inferiority, disgust, guilt, and hostility are capable of considerable modification.

Many nurses are genuinely interested in their patients as human beings and are puzzled by the behaviour problems they present. However, partly because of thoughtlessness and partly because of lack of training in matters of elementary psychology, nurses leave much to be desired in the psychological handling of their patients. Nursing tuberculous patients is not always very interesting; it could be made much more interesting for nurses if the human factor were introduced into their training.

Tuberculous patients rarely leave hospital against the advice of their doctors on the grounds that they are dissatisfied with the medical treatment. Their reasons for leaving can generally be attributed to emotional problems. It should be remembered, however, that the patients who remain in hospital still have to handle the same kinds of feelings which motivated the others to leave. To meet this difficulty, Wilmer,[5] a psychiatrist, who had himself made a satisfactory recovery from pulmonary tuberculosis, demonstrated the value of

group therapy. He showed that realistic acceptance of membership of a small group permitted easier acceptance of membership of the larger hospital group, as well as a more mature acceptance of the disease and its meaning by the patients' family and friends. Moreover, this approach facilitated the rehabilitation of patients after their discharge from hospital.

REHABILITATION

Rehabilitation is one of the most pressing challenges o modern medicine. Rehabilitation requires team work—not the team work of a conference, but team work in action. It involves physicians and relatives, labour unions and employers, public health nurses, and social agencies. It requires more than goodwill and a promise to cooperate. Rehabilitation begins, as Coleman[6] said, with orientating the patient to his illness. It includes realistic evaluation of the organic and emotional factors in the patient, and the social, vocational and psychological factors in the community to which he is returning. It includes a concrete plan for out-patient treatment, help in finding employment, help in overcoming prejudice, facilities for maintaining physical and mental health, vocational re-training—if indicated—and some technique for gradually 'hardening' the patient psychologically as well as physically to the non-protective climate of the outside world. To permit the patient to plunge into a rushed life which will re-activate the disease, is folly, and to restrict him so narrowly that he is hardly able to participate in the events of the world, is also folly. To help him steer a middle course is the real solution.

The social worker can make a unique contribution to the rehabilitation of the patient. In addition to her usual functions, she has the special task of helping to interpret the nature of this infectious disease to the public and the family. She also has to mobilize the community resources in vocational placement and in public health. In addition, since tuberculosis has a social as well as a pulmonary pathology, the social worker should also be helpful in assisting in the reduction of premature discharges from hospital, many of which are due to social, environmental and family factors.

Well-organized rehabilitation within the community is, in fact, an efficient method of group therapy on a large scale. The invalid recognizes that he is emotionally, socially and economically no longer an outcast, but that he 'belongs' somewhere, and that something constructive is being done for him.

Recent advances in the treatment of tuberculosis in well-institutionalized European countries, have given rise to new hope that the 'scourge of the White man' will be eliminated in the foreseeable future. The average duration of stay in hospital has been reduced by means of modern drugs to about 3 months, and the emphasis today is on rehabilitation.

THE AFRICAN

What is the position regarding tuberculosis in the African? In Natal, for example, 12·37 per 1,000 of the African population contract the disease. In the African the insidious onset of tuberculosis, which is so common in the European, is the exception; for him it is often an acute fulminating disease with a strong tendency to miliary dissemination.

What is the psychological reaction of the African to a diagnosis of pulmonary tuberculosis as compared with the average European? He often cares very little and would abscond from the ordinary hospital the moment he felt better. The problem of treating these patients successfully seems almost impossible, especially in view of the fact that with the aid of modern drugs the temperature can usually be reduced to normal within 3 weeks, and the drugs themselves often induce a mild state of euphoria.

It should be remembered, however, that the cultural background of the African is a patriarchal society composed of large family groups governed by primitive taboos. Infringement of these rules implies antisocial motives, and in this setting, even solitary and outstanding people are suspect. Logic, speculation, and the search for causes are supplemented by magic and animism and, when these fail, only the witch doctor and the ancestral spirits can help. The spirits, moreover, can be approached only by the group and not by an individual.

Gallais and Planques,[7] observing the African from a European frame of reference, state that the most striking traits of the African are the recognition of the importance of physical needs (nutrition and sexuality), and a liveliness of the emotions counterbalanced by their short duration. The African lives essentialiy in the present (in a sense, like a child) and his behaviour is largely motivated by influences and impulses of the moment.

The African, with this cultural background, has now been subjected to the impact of Western civilization. The indentured African has left his kraal and has embarked on a venture into, what appears to him, a rather gay, rather irresponsible meaningless world, with the restraints of his normal environment in abeyance. Finally, he exists on a diet lacking in a variety of constituents necessary to maintain his physical and mental health, and he faces life with lowered resistance to disease and with general impairment of efficiency.

Pulmonary tuberculosis in the African is often a family affair as well as a family epidemic and everything possible should be done to meet this situation if the patient is to continue his treatment in hospital. To this end the wards of the admission blocks of some hospitals where Africans are treated are only separated by walls 3 feet in height so as to preserve the sense of community life. As soon as the patient's temperature is normal, which is usually about 3 weeks after admission, he is transferred to attractively equipped open wards surrounded by pleasant lawns, and visitors are encouraged. Occupational therapy, and not group therapy—which is quite unnecessary—is prescribed, and an incentive is provided by a definite system of remuneration.

Dormer *et al.*[8] have recently reported that in King George V Hospital in Natal, with over 1,000 beds for African patients with pulmonary tuberculosis, about 20 babies are born each year. Until 1955 these babies were immediately separated from their mothers and sent to other institutions or foster parents or relatives. However, when the feeding is not carried out by the mother of the child, a very high mortality results. While it is always desirable, where possible, to keep a mother and child together, in a backward community it is life-saving. The mothers who have their children with them are contented and the babies are beautiful, thriving children.

From their experience over a period of 3 years, Dormer *et al.*[8] feel that isoniazid, given prophylactically, can completely protect a child from infection with tubercle bacilli. A child treated prophylactically does not develop any immunity and, as soon as the administration of the drug is stopped, the

child will; if exposed, become re-infected. These authors stated that isoniazid was given prophylactically to 98 newborn infants so that they might remain with their mothers in a tuberculosis ward. Given regularly, the prophylactic use of isoniazid has completely prevented tuberculous infection occurring in these children. The mothers have been allowed to breast-feed and fondle their children as much as they like, without adverse effects on mother or child.

CONCLUSION

Specialization has brought many triumphs to medicine. It has also brought one evil—the curious departmentalization of the human body. The victim is often the patient who has been so unfortunate as to acquire two diseases which fall under the jurisdiction of different specialists or, what may be even worse, two government departments.

It would be a catastrophe if this anomalous situation were to create the feeling in the minds of general practitioners that tuberculosis is the responsibility of others.

The practitioner deals with sick people, and tuberculosis is more common among those who feel ill than among those who feel well. The practitioner is the man who first sees the sick person and who knows his environment; therefore, the general practitioner, who is constantly aware of the threat of tuberculosis, remains the mainstay in the fight against this disease.

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